MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Outpatient Services • Chronic Dialysis Clinics

June 2007 • Bulletin 393

Contents

2007 CPT-4/HCPCS Updates: Implementation August 1, 2007

The 2007 updates to the *Current Procedural Terminology – 4th Edition* (CPT-4) and Healthcare Common Procedure Coding System (HCPCS) National Level II codes will be effective for Medi-Cal for dates of service on or after August 1, 2007. Specific policy changes are detailed below. Unless otherwise stated, the policy of deleted code(s) applies to the replacement code(s). Providers are reminded that Medi-Cal enforces CPT-4 instructions.

PATHOLOGY

Billing Restrictions

The following CPT-4 codes must be billed with the appropriate split-bill modifiers (26, 99, TC or ZS): 82107, 83698, 83913, 86788, 86789, 87305, 87498, 87640, 87641, 87653 and 87808.

Code 88314 is not reimbursable with codes 17311 – 17315 for a routine frozen section stain. However, it is separately reimbursable for a non-routine frozen section stain when it is billed with modifier 59.

Codes 88302 – 88309 (surgical pathology) are not reimbursable with codes 17311 – 17315 (Mohs surgery) unless there is documentation that the pathology claims are for different specimens.

DRUGS, INJECTIONS AND BLOOD FACTORS

Deleted and Replacement Codes

Deleted Code	Replacement Code
J7188	J7187
X7484	Q4084

Billing Restrictions

Injection code C9233 (ranibizumab [Lucentis™]) is reimbursable with prior authorization. Providers must document on the *Treatment Authorization Request* (TAR) that the patient has exudative senile macular degeneration (ICD-9-CM code 362.52). Reimbursement is limited to 12 injections per eye, per year. Providers should bill with the appropriate site modifiers (LT, RT or 50 if bilateral). C9233 must be billed on the same claim as CPT-4 code 67028 (intravitreal injection of a pharmacologic agent).

Injection codes J0348 (andulafungin, 1mg) may be billed up to 200 mg and must be billed with ICD-9-CM diagnosis codes 112 – 112.9.

Injection code J0894 (decitabine, 1 mg) is reimbursable for patients with myelodysplastic syndrome. Claims must be billed with ICD-9-CM diagnosis codes 238.72 – 238.75. Maximum dosage for three consecutive days is 122 mg per day unless there is documentation that the Body Surface Area (BSA) is greater than 2.7 m^2. Treatment may be repeated in six weeks.

Please see **CPT-4/HCPCS**, *page 2*

Injection code J1740 (ibandronate sodium, 1 mg [Boniva™]) is reimbursable for the treatment of women with post-menopausal osteoporosis. Claims must be billed with ICD-9-CM diagnosis code 733.01. Providers must submit the following documentation, either in the *Remarks* field (Box 80) or on an attachment:

- A diagnostic T score of -2.5 or more in women who have documented difficulty with the oral bisphosphonates dosing requirement, which includes an inability to sit upright for 30 to 60 minutes and/or difficulty in swallowing a pill; or
- A diagnostic T score of -2.5 or more in women with documented esophagitis, gastritis, gastric or esophageal ulcers that prohibit the use of oral bisphosphonates

Dosing frequency is 3 mg every three months administered intravenously over 15-30 seconds by a health care provider. Boniva is contraindicated in patients with hypocalcemia or those who have a known hypersensitivity to ibandronate sodium.

Code J2248 (micafungin sodium, 1 mg) may be billed up to 150 mg and must be billed with ICD-9-CM diagnosis codes 112-112.9.

Code J3243 (tigecycline, 1 mg) may be billed up to 100 mg.

HCPCS codes J7611 and J7613 (albuterol inhalation solution, 1 mg) will be added as Medi-Cal benefits. Claims billed in excess of 30 mg will be cut back unless the provider submits documentation, either in the *Remarks* field (Box 80) or on an attachment, that the patient required more than the allowed amount due to continued airflow obstruction.

Injection code J9261 (nelarabine, 50 mg) is reimbursable to patients with lymphosarcoma or acute lymphoid leukemia. Claims must be billed with ICD-9-CM diagnosis codes 200.10 – 200.18 or 204.00 – 204.01. Maximum daily dosage on days one, three and five is 4,050 mg unless documentation BSA is greater than 2.7 m^2. Treatment may be repeated in 21 days.

Injection code J9035 (bevacizumab 10 mg [Activa®]) will be activated to replace deleted code S0116 (bevacizumab, 100 mg).

- Code J9035 must be billed in conjunction with diagnosis codes 153.0 – 154.8 (malignant neoplasm of the colon, rectum, rectosigmoid junction and anus) or 162.2 – 162.9 (malignant neoplasm of bronchus and lung).
- The provider must document that treatment was either for metastatic colorectal cancer or for unresectable, locally advanced, recurrent or metastatic non-squamous, non-small cell lung cancer.

Bevacizumab is packaged in 100 mg vials. If it is necessary to waste the unused portion of a vial, providers may bill for a quantity that is equal to the amount given to the patient plus the amount wasted. Providers must justify in the *Remarks* field (Box 80) of the claim the amount of bevacizumab that was wasted.

Injection codes Q4084 (Synvisc), Q4085 (Euflexxa) and Q4086 (Orthovisc) are reimbursable, with prior authorization.

The TAR may be approved for one or both knees when there is documentation of one of the following conditions:

- Painful osteoarthritis of one or both knees
- Significant knee pain, decreased mobility, or significant effusion of one or both knees
- Knee pain that is not relieved with use of non-steroidal anti-inflammatory drugs (NSAIDs)

Please see **CPT-4/HCPCS**, *page 3*

Quantity and frequency restrictions:

- Synvisc and Euflexxa are restricted to a total of three injections per knee (one injection, one week apart, for a total of three weeks) in a six month period.
- Orthovisc is restricted to a total of four injections per knee (one injection, one week apart, for a total of four weeks) in a six month period.

The manual replacement pages reflecting these policies will be released in the July *Medi-Cal Update.*

Redirection of Treatment Authorization Request Services

Effective July 1, 2007, several regionalized *Treatment Authorization Request* (TAR) services provided by the Fresno Medi-Cal Field Office (FMCFO) are being redirected to the Northern and Southern Pharmacy Sections (NPS and SPS), Sacramento Medi-Cal Field Office (SMCFO) and San Francisco Medi-Cal Field Office (SFMCFO).

TAR services currently handled by the FMCFO will be redirected as follows:

- Intravenous home infusion equipment services, including all medical supplies related to infusion therapy, and all Durable Medical Equipment (DME) and medical supplies related to enteral feeding, have been redirected to the NPS and SPS.
- Medical supplies related to incontinence, including urinary catheters and bags, have been redirected to the SMCFO.
- Breast pumps and supplies have been redirected to the SFMCFO.
- Physician-administered drugs and/or physician-performed services/procedures, radiology services, inpatient and outpatient surgeries and procedures that require a TAR and elective acute hospital admissions have been redirected to the SMCFO.

Providers located in Oregon border cities were required to submit their TARs, for core services only, to SMCFO effective May 1, 2004.

The California Department of Health Services (CDHS) does not anticipate any delays in adjudication of these TAR types.

Manual replacement pages will be released in a future *Medi-Cal Update*.

Processing Changes for Treatment Authorization Requests

Beginning May 1, 2007, the California Department of Health Services (CDHS) started phasing in several changes that impact how paper *Treatment Authorization Requests* (TARs) are processed.

These changes are being implemented to minimize the key data entry of incomplete or erroneous TAR information and to reduce the volume of paper documents containing Protected Health Information (PHI), particularly Social Security Numbers (SSNs) that are sent via:

- United States Postal Service
- Courier services
- Other types of delivery services

CDHS expects to complete this phased implementation by September 2007.

Please see **Processing Changes**, *page 4*

Processing Changes *(continued)*

Processing Change Schedule

Processing changes to paper TARs impact providers interacting with the Medi-Cal field offices and pharmacy sections on the following dates:

May 2007 Sacramento Medi-Cal Field Office	**August 2007** Fresno Medi-Cal Field Office San Bernardino Medi-Cal Field Office San Diego Medi-Cal Field Office San Francisco Medi-Cal Field Office
June 2007 Northern Pharmacy Section (Stockton) Southern Pharmacy Section (L.A.)	
July 2007 L.A. Medi-Cal Field Office In-Home Operations South	**September 2007** TAR Administrative Remedy Section In-Home Operations North

Incomplete TARs

CDHS Medi-Cal field offices and pharmacy sections will be unable to enter paper TARs with incomplete information into the TAR system. These paper TARs will be deferred back to the submitting provider, with a Medi-Cal field office/pharmacy section *Incomplete TAR Form* identifying the reasons for deferral and instructions about how to resubmit the paper TAR with the necessary corrections.

Providers are to:

- Make the necessary corrections/changes on the paper TAR, and
- Resubmit with a copy of the *Incomplete TAR Form* on top of the paper TAR.

Paper TARs that are returned to the submitting provider for correction will not be available for inquiry through the Provider Telecommunications Network (PTN).

Any one of the reasons below will not allow the paper TAR information to be entered into the system. The reason(s) will be marked on the *Incomplete TAR Form* and sent back to the submitting provider for corrections. These reasons may consist of one or more of the following:

- The TAR form is illegible or damaged.
- The submitting provider number is missing, inactive, suspended or invalid for the category of service requested.
- The patient's Medi-Cal ID number is missing, invalid or invalid in length, and the patient's name/date of birth is missing.
- The patient is not Medi-Cal eligible.
- Information in the *Admit From* field (Box 14) on the *Long Term Care Treatment Authorization Request* (LTC TAR, form 20-1) is missing or invalid.
- The requested service information is missing, invalid or invalid in length.
- The ICD-9-CM diagnosis code, admitting ICD-9-CM diagnosis code and/or primary DX diagnosis code is missing or invalid.
- The County Medical Services Program (CMSP) pharmacy services are covered by MEDIMPACT. Providers may call 1-800-788-2949 for further information.
- The requested Adult Day Health Care (ADHC) service should specify the months and the number of requested days for each calendar month on separate lines of the TAR. The TAR request should not exceed six months or have more than one service line for a given calendar month. Providers may refer to the appropriate Part 2 manual for specific TAR preparation instructions.

Please see **Processing Changes**, *page 5*

Processing Changes *(continued)*

Adjudication Response
CDHS will discontinue the practice of returning adjudicated paper TAR copies to providers based on the schedule above. Instead, providers will receive an *Adjudication Response* (AR), which will display:

- The status of requested service(s)
- The reason(s) for the decision(s), including TAR decisions resulting from an approved or modified appeal
- The adjudicator's request for additional information, if necessary

The AR will enable the provider to respond to the requested information or proceed to bill for authorized services. (See the *Adjudication Response* example at the end of this article.) Providers should keep a copy of the AR for their records and use it when responding to deferrals or when requesting an update/correction to a previously approved or modified TAR.

When requesting an update/correction, a copy of the AR must be placed on top of newly submitted documents to ensure the information can be matched with previously submitted documentation. Providers should clearly specify what change(s) are being requested.

The ARs will be mailed to the provider's address on file with CDHS' Payment Systems Division, Provider Enrollment Branch (PEB). Providers should ensure PEB has their most up-to-date mailing address on file. Instructions about changing/updating a provider address may be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**). From the home page, click the "Provider Enrollment" link and then the "Provider Reminders" link at the top of the page.

Attachments
On November 15, 2006, CDHS notified providers via a flyer that attachments were no longer being returned with deferred paper TARs. Medi-Cal field offices and pharmacy sections will continue to retain and archive all attachments for reference.

Providers responding to a deferred TAR should return the AR and any new attachment(s) requested.

SSN on TARs
In accordance with *Medi-Cal Updates* issued in August and September 2006, providers should use the recipient's Benefits Identification Card (BIC) number on the TAR, rather than the SSN. If a TAR is returned to a provider because of inaccurate and/or incomplete information, the SSN will be removed.

Provider questions may be directed to the local Medi-Cal field office or pharmacy section.

National Provider Identifier (NPI) Number
Providers should be aware that the NPI number will not be accepted on TARs until after the official NPI implementation date of November 26, 2007. For detailed information about the new NPI implementation date, providers can view the "Important NPI Time Frame Changes" article posted in the "HIPAA News" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**).

TARs issued under the old provider number (legacy number) prior to November 26, 2007 can still be used for claims submitted with an NPI starting on or after November 26, 2007. Providers will not have to request an updated TAR with the NPI information.

Please see **Processing Changes**, *page 6*

Processing Changes *(continued)*

State of California - Health and Human Services Agency
Department of Health Services

CONFIDENTIAL

Medi-Cal Operations Division

ARNOLD SCHWARZENEGGER, Governor

ADJUDICATION RESPONSE

Provider Number: HSCXXXXXX
XXX CONTRACT HOSP #2
3215 PROSPECT PARK DR
RNCHO CORDOVA, CA 95670-6017

DCN (Internal Use Only): 123456789101
Date of Action: 06/27/2006
Regarding: Jane Doe
TAR Control Number: 9876543210

This is to inform you that a Treatment Authorization Request has been adjudicated. If you have any questions regarding this adjudication response, please contact your local Medi-Cal Field Office. The decision(s) follow:

Svc #	Service Code	Modifier(s)	Service Description	From Date of Service	Thru Date of Service	Units	Quantity	Status	P.I.
1	123ABC	1	Service Description 1	01-01-2006	01-31-2006	12345	1000000.123	1 Approve	1
2	ABC123	2	Service Description 2	01-01-2006	01-31-2006	12345	1000000.123	2 Modify	0
	Reason(s):	GEN: Modified, refer to comments							
	Comment(s):	Comments from Field Office Consultant 2							
3	ABC123	3	Service Description 3	01-01-2006	01-31-2006	12345	1000000.123	3 Deny	3
	Reason(s):	GEN: Denied, refer to comments							
	Comment(s):	Comments from Field Office Consultant 3							
4	ABC123	4	Service Description 4	01-01-2006	01-31-2006	12345	1000000.123	4 Defer	5
	Reason(s):	GEN: Deferred, refer to comments							
	Comment(s):	Comments from Field Office Consultant 4							

Authorization does not guarantee payment. Payment is subject to Patient's eligibility. Please ensure that the Patient's eligibility is current before rendering service.

If you have received this document in error, please call the Telephone Service Center, 1-800-541-5555 in California, 1-916-636-1200 out-of-state (follow the prompts for eTAR), to notify the sender. Please destroy this document via shredder or confidential destruction.

Emergency Fix for Crossover Claims in Excess of 15 Lines

An *Updated Information* bulletin was released in March announcing that effective April 1, 2007, Medicare contractors began requiring End-Stage Renal Disease (ESRD) dialysis facilities to bill their monthly repetitive services separately by date of service. Because of this, dialysis claims will likely exceed Medi-Cal's 15-line limit for electronic automatic crossover claims.

To mitigate the adverse effect on providers, EDS is implementing an emergency system fix to enable Medi-Cal to process these claims. Beginning with claims received from Medicare in June 2007, EDS is expected to split all automatic electronic outpatient crossover claims with more than 15 lines into separate claims. Once the claims are processed, EDS will prepare a separate *Remittance Advice Details* (RAD) for each claim.

EDS will also hold and reprocess all outpatient crossover claims in excess of 15 lines received from Medicare and rejected by Medi-Cal between May 1, 2007 and when the system fix is implemented. Providers will not be required to rebill these claims. However, for any outpatient crossover claims with more than 15 lines that do not cross over automatically, providers will still be required to rebill the claims to Medi-Cal either electronically according to the instructions for Computer Media Claims (CMC), or on paper according to the instructions in the *Medicare/Medi-Cal Crossover Claims: Outpatient Services* section of the Part 2 manual.

Please visit the "What's New" area of the Medi-Cal Web site (**www.medi-cal.ca.gov**) to obtain updates regarding this issue.

This information is reflected on manual replacement pages medi cr op 9, 12 and 15 (Part 2).

Enzyme Replacement Drugs Reimbursement Update

Effective for dates of service on or after July 1, 2007, the following codes are now Medi-Cal benefits.

HCPCS Code	Description
C9232	Idursulfase, 1 mg, is for the treatment of Hunter syndrome (Mucopolysaccharidosis Type II [MPS II]).
C9234	Alglucosidase alfa, 10 mg, is for the treatment of Pompe Disease.
J1458	Galsulfase, 1 mg, is for the treatment of Maroteaux-Lamy Syndrome (Mucopolysaccharidosis Type VI [MPS VI]).

A *Treatment Authorization Request* (TAR) is required for the reimbursement of enzyme replacement drugs and must be submitted to the Los Angeles Medi-Cal Medical (not Pharmacy) Field Office (LAMFO). Initial drug therapy will be approved on a 3- or 6-month trial basis. Renewal of the TAR will require that follow-up documentation be submitted to the field office. For children under 21 years of age, a Service Authorization Request (SAR) should be made through California Children's Services (CCS).

See the "TAR Requirements" subsection under the specific drug name in the *Injections* section of the appropriate Part 2 provider manual for specific information on TAR submissions.

HCPCS Code Updates and Reminder
Age restrictions are removed from both laronidase (code J1931) and agalsidase beta (code J0180). Also, the correct diagnosis for laronidase is "Mucopolysaccharidosis Type I or Hurler, Hurler-Scheie or Scheie's syndrome."

This information is reflected on manual replacement pages inject 58 thru 60 (Part 2) and inject list 2, 8 and 9 (Part 2).

Billing Ranibizumab with HCPCS Code J3590

Providers are reminded to use HCPCS code J3590 (unclassified biologics) when billing for ranibizumab, a drug used in treatment of exudative senile macular degeneration. This drug requires a *Treatment Authorization Request* (TAR), which must be sent to the appropriate Medi-Cal field office with required documentation. For instructions to bill for J3590, providers may refer to "Unlisted Injections: HCPCS Codes Billed 'By Report' " in the *Injections* section.

Note: The policy for code J3590 will only be effective through date of service July 31, 2007. On August 1, 2007, providers should use code C9233 (ranibizumab) when it becomes effective as part of the 2007 HCPCS code update.

HCPCS updates will be released in a future Medi-Cal provider bulletin.

Infliximab Diagnoses Expanded

Effective for dates of service on or after July 1, 2007, infliximab (Remicade) 100 mg (HCPCS code X7480) is now reimbursable for the treatment of plaque psoriasis.

Documentation stating that plaque psoriasis covers 10 percent or more of the patient's body surface area must be on or attached to an approved *Treatment Authorization Request* (TAR).

This information is reflected on manual replacement page inject 44 (Part 2).

Billing Code for Abatacept Revised

Effective for dates of service on or after July 1, 2007, abatacept (Orencia) 10 mg is billed with HCPCS code J0129 rather than code J3590 (unclassified biologics).

Abatacept is approved for the treatment of moderate to severely active rheumatoid arthritis (RA) in adult recipients, 18 years of age or older. A *Treatment Authorization Request* (TAR) is required and must document that the patient has had an inadequate response after treatment with:

- Two or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs), and
- At least one of the tumor necrosis factor (TNF) antagonists (infliximab, etanercept or adalimumab) or the interlukin-1 receptor antagonist, anakinra (inadequate response after at least one month of treatment).

In addition, the TAR must include all of the following:

- A requested dose of abatacept for 1000 mg or less (a quantity of "100" or less in the quantity field of the TAR)
- ICD-9-CM code 714.0, 714.1 or 714.2
- Documentation that the patient is 18 years of age or older

This information is reflected on manual replacement pages inject 45 and 46 (Part 2) and inject list 2 (Part 2).

Nonspecific ICD-9-CM Codes Not Billable with a Lab Procedure Code

Effective for dates of service on or after July 1, 2007, the following nonspecific ICD-9-CM diagnosis codes are not billable with a laboratory procedure code: V70, V70.0, V70.5 – V70.9, V72, V72.1 and V72.9.

This does not change the policy that any laboratory procedure must be billed with a diagnosis code, nor does it change the policy requiring specific diagnosis codes for certain laboratory procedures. Providers billing a laboratory procedure code with any of the above diagnosis codes will have their claims denied for nonspecific diagnosis.

This information is reflected on manual replacement page path bil 1 (Part 2).

Updated VFC Coverage and Influenza Vaccine Codes Reimbursement

The Vaccines for Children (VFC) Program has updated its coverage of free vaccines. The following is a complete list of these CPT-4 vaccine codes: 90633, 90647 – 90649, 90655 – 90658, 90660, 90669, 90680, 90700, 90707, 90710, 90713 – 90716, 90723, 90734, 90743, 90744 and 90748. For detailed descriptions of these codes, see the *Vaccines For Children (VFC) Program* section in the Part 2 provider manual.

Providers should also be aware that influenza vaccines (CPT-4 codes 90655 – 90658) are now considered routine injections and do not require "high risk" documentation or the use of modifier SK for administration fee reimbursement.

This information is reflected on manual replacement pages modif used 4 (Part 2) and vaccine 2 thru 4 (Part 2).

Medi-Cal Share of Cost and Medicare Part D Reminder

Medicare-eligible recipients with a Medi-Cal Share of Cost (SOC) are not eligible for Medi-Cal benefits until their SOC is met. Under the Medicare Part D prescription drug program, Medicare beneficiaries with a Medi-Cal SOC may have higher prescription drug payment obligations than beneficiaries without an SOC. These payment obligations may include deductibles and copayments.

All medically necessary health services, whether covered by Medi-Cal or not, can be used to meet SOC for Medi-Cal purposes. All prescription drug payments required under Medicare Part D are considered medically necessary health services. For more information, refer to the Part 1 provider manual.

Prescription drug payments required under the Medicare Part D prescription drug program should be applied to the recipient's SOC upon receiving payment or accepting obligation for payment from the recipient. Delays in performing the SOC clearance transaction may prevent the recipient from receiving other medically needed services.

Correction: RhuEPO Therapy Target

The May 2007 *Medi-Cal Update* incorrectly listed the therapy target for recombinant human erythropoietin (RhuEPO). The target was listed as:

Hct < 39% and/or Hgb 13g/dl.

The "less than" symbol should instead be the "less than or equal to" symbol. The correct target is:

Hct $\leq$ 39% and/or Hgb 13g/dl.

Instructions for Manual Replacement Pages — Part 2

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Remove and replace at the end of the *Manual Ordering* section:	*Subscriber Order Form* 1/2 *
Remove and replace:	forms reo io 1/2 * inject 43 thru 46, 57 thru 60 inject list 1/2, 7 thru 10, 13/14 *, 19 * medi cr op 9 thru 12, 15/16 medi non hcp 1/2 * modif used 3/4 oth hlth cpt 1/2 * path bil 1/2 supp drug op 1 thru 4 * tar comp 1 thru 13 * tar dis 7/8 *
Remove:	tar sub clk 1 thru 3
Remove and replace:	tar submis 3 *
Remove: Insert:	tar submit 1/2 tar submit 1 *
Remove and replace:	vaccine 1 thru 4

* Pages updated due to ongoing provider manual revisions.